Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Geneva Medical Management, Inc. P O BOX 121589 Arlington, Texas 76012	MFDR Tracking #: M4-07-7242-01 (current MDR #) M4-07-6501-01 (former MDR #) M4-07-5083-01 (former MDR #) DWC Claim # Injured Empl
Respondent Name and Box #: Dallas ISD Rep Box # 42	Date of Injury Employer Na Insurance Ca

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE D

Requestor's Position Summary: Per the Table of Disputed Services "Billed per Medical Fee Guidelines."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $200.00
3. CMS 1500(s)
4. EOB(s)

Sent
SEP 04 2007
TX DEPARTMENT OF INSURANCE
DIVISION OF WORKERS'
COMPENSATION

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: Respondent did not submit a position summary.

Principle Documentation:

1. Response to DWC 60

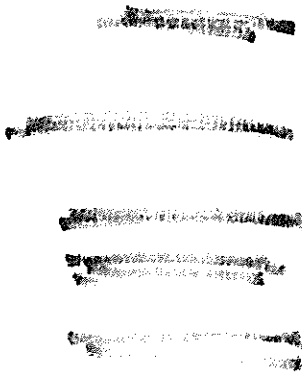
PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Code(s) and Calculations	Part V Reference	Amount in Dispute	Ordered Amount
02-20-2007	99456-RE-59 ($350.00 minus payment of $150.00)	1 - 3	$200.00	$200.00
Total Due:				$200.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Section §413.011(a-d) titled, *Reimbursement Policies and Guidelines*, and Division Rule 134.202 titled, *Medical Fee Guideline* effective August 1, 2003, sets out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code "97H" (payment is included in the allowance for another service/procedure) and "W4" (No additional reimbursement allowed after review of appeal/reconsideration).



2. CPT code 99456-RE-59 was billed alone for date of service 02-20-07. Per Rule 134.202(b) the service is not global.

3. Per Advisory 2004-06: Billing for Return to Work (RTW) and/or Evaluation of Medical Care (EMC) examinations a designated doctor can be assigned to address several topics and a designated doctor who addresses one or more of the new issues should bill using CPT code 99456 with an "RE" modifier. The doctor may bill and be reimbursed $350 for each evaluation, any of which occurred in a single examination. In such cases, the doctor may use modifier "59" to indicate that the services performed to complete the carrier's request were distinct or independent, but appropriate under the circumstances. The reimbursement includes Division required reports. The Requestor billed for an MMI evaluation plus two body areas for an IR evaluation (Upper Extremity ROM and Lower Extremity ROM). In addition, the Requestor performed and billed for a Return to Work evaluation, Extent of Injury evaluation and a Causation evaluation. All of the evaluations billed for are allowed per Advisory 2004-06 and reimbursable in the amount of $350.00 for each evaluation. The Respondent has made a partial payment of $150.00. Per Advisory 2004-06 and Rule 134.202(e)(7) additional reimbursement is recommended in the amount of $200.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code Sec. §134.1 and 134.202
Subchapter G, Chapter 2001, Texas Government Code
Advisory 2004-06

PART VII: DIVISION DECISION AND ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, section §413.031, the Division has determined that the Requestor is entitled to additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $200.00 plus applicable accrued interest per Division Rule 134.130 due within 30 days of receipt of this Order.

ORDER:

[redacted] [redacted] 9-4-07

Authorized Signature | Medical Fee Dispute Resolution Officer | Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.